Health Care Directive (Living Will)

Directive made this _____ day of _____, 20___.

I, _____,

having the capacity to make health care decisions, willfully and voluntarily make known my desire that my dying shall not be artificially prolonged under the circumstances set forth below, and do hereby declare that:

1. If at any time I should be diagnosed in writing to be in a terminal condition by the attending physician, or in a permanent unconscious condition by two physicians, and where the application of life-sustaining treatment would serve only to artificially prolong the process of my dying, I direct that such treatment be withheld or withdrawn, and that I be permitted to die naturally. I understand in using this form that a terminal condition means an incurable and irreversible condition caused by injury, disease, or illness, that would within reasonable medical judgment cause death within a reasonable period of time in accordance with accepted medical standards, and where the application of life-sustaining treatment would serve only to prolong the process of dying. I further understand in using this form that a permanent unconscious condition means an incurable and irreversible condition in which I am medically assessed within reasonable medical judgment as having no reasonable medical probability of recovery from an irreversible coma or a persistent vegetative state.

2. In the absence of my ability to give directions regarding the use of such life-sustaining treatment, it is my intention that this Directive shall be honored by my family and physician(s) as the final expression of my legal right to refuse medical or surgical treatment, and I accept the consequences of such refusal. If another person is appointed to make these decisions for me, whether through a Durable Power of Attorney or otherwise, I request that the person be guided by this Directive and any other clear expressions of my desires.

3. If I am diagnosed to be in a terminal condition or in a permanent unconscious condition (**check one**):

☐ I DO want to have artificially provided nutrition and hydration.

☐ I DO NOT want to have artificially provided nutrition and hydration.

4. If I have been diagnosed as pregnant and that diagnosis is known to my physician, this Directive shall have no force or effect during the course of my pregnancy.

5. I understand the full impact of this Directive and I am emotionally and mentally capable of making the health care decisions contained in this Directive.

6. I understand that before I sign this Directive, I can add to or delete from or otherwise change the wording of this Directive, and that I may add to or delete from this Directive at any time and that any changes shall be consistent with Washington state law or federal constitutional law to be legally valid.

7. It is my wish that every part of this Directive be fully implemented. If for any reason any part is held invalid, it is my wish that the remainder of my Directive be implemented.

Signed: _____

Street Address _____

City, County, State _____

Witness

This Directive must be signed by two witnesses. The following persons may *not* serve as witnesses: (a) anyone related to the declarer by blood or marriage; (b) anyone entitled to part of the declarer's estate, by Will or otherwise; (c) anyone with a claim against the declarer's estate; (d) the declarer's attending physician or any of the physician's employees; or (e) the employees of a health facility (hospital or nursing home) in which the declarer may be a patient.

The declarer is personally known to me and I believe him or her to be of sound mind.

Witness: _____

Address: _____

Witness: _____

Address: _____